DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
445362		B. WING	3	09	09/29/2021		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FENTRESS COUNTY				STREET ADDRESS, CITY, STATE, ZIP CODE 208 DUNCAN ST N JAMESTOWN, TN 38556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Survey was conduction 9/29/2021 at Sig Fentress County. T	sed Emergency Preparedness sted by the State Agency (SA) gnature Healthcare Of the facility was found to be in CFR §483.73 related to	E	000			
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	445362	B. WING			09/29/2021		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FENTRESS COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 208 DUNCAN ST N JAMESTOWN, TN 38556				
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
was conducted 9/29/2021 at Si County. The fa compliance wit regulations and Medicare and Medicare for Dis (CDC) recomm COVID-19. Total	bocused Infection Control Survey by the State Agency (SA) on gnature Healthcare Of Fentress cility was found to be in a 42 CFR §483.80 infection control has implemented the Centers for Medicaid Services (CMS) and ease Control and Prevention ended practices to prepare for		TITLE			(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Health Care Facilities
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		TN2502	B. WING		09/	29/2021			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SIGNATURE HEALTHCARE OF FENTRESS CO JAMESTOWN, TN 38556									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE			
N 000	was conducted by to 9/29/2021 at Signar County. The facility compliance with infination has implemented the Medicaid Services Disease Control and recommended practices.	ection control regulations and ne Centers for Medicare and (CMS) and Centers for d Prevention (CDC) ctices to prepare for COVID-19 0-8-6, Standards for Nursing	N 000						

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE